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MEDICARE: PAYING THE PHYSICIAN—HISTORY, ISSUES, AND OPTIONS

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UNITED STATES SENATE

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PREFACE

The Special Committee on Aging has long been concerned with the adequacy and financial health of the medicare program. Most of the attention of Congress to date has focused on the hospital insurance (HI) trust fund, also known as medicare part A. This information print analyzes the other part of the program, medicare part B, also known as the supplementary medical program (SMI), which pays for physician services.

SMI now represents about one-third of total medicare costs. It has grown in recent years at a faster rate than have HI expenditures. As of 1984, the SMI expenditures are rising at about 16 percent annually—more than four times as fast as the overall rate of inflation. Seventy-five percent of SMI expenditures are for physician services. The program will soon become the third largest Federal domestic program—after only social security (OASDI) and medicare part A (HI).

There is clearly a need for better understanding of these costs, and for analysis of the policy options available to the Congress that might help slow the growth of these expenditures.

This information print was prepared at the request of the committee by Lynn Etheredge. Mr. Etheredge served more than 10 years with the Office of Management and Budget, from 1978 to 1982 as Chief of its Health Branch. He is currently an independent consultant.

JOHN HEINZ, *Chairman.*

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MEDICARE: PAYING THE PHYSICIAN—HISTORY, ISSUES, AND OPTIONS

EXECUTIVE SUMMARY

The medicare program's physician payment policies need to be reconsidered in light of the Federal budget deficit and a rapidly changing health system. In 1985, medicare's supplementary medical insurance (SMI) will be the third largest Federal domestic program ($25 billion)—exceeded only by social security and the medicare hospital insurance program. With a 16.1 percent increase from 1984 to 1985, SMI will be the fastest growing of the major domestic programs.

Medicare's expenses for physicians services are rising—even more rapidly than private sector costs—largely because it pays physicians on the basis of what they ask to be paid. The combination of provider-determined rates and fee-for-service bills with a rapidly rising physician supply and new technology has accelerated spending for physicians services. These payment policies—a compromise to gain physician acceptance when medicare was enacted in 1965—have also distorted incentives for appropriate medical care and created unintended inequities among primary care physicians and specialists, inpatient and outpatient care, urban and rural areas.

Medicare's assignment policies must be reconsidered along with redesign of its payment policies. Unless these policies are changed, physicians could simply respond to medicare fee reforms by passing on unreimbursed charges to patients. Physicians now refuse to accept assignment on a majority of claims where assignment is not required.

The health sector has been changing rapidly since medicare was enacted. National health spending is up more than eight times, from $42 billion in 1965 to an estimated $362 billion last year, and the Nation's physician supply has risen 70 percent. Solo office practice has been replaced by group practice for a majority of physicians, and increasing numbers of physicians have contracts with hospitals or are employed by other groups, e.g., HMO's. In such arrangements, time-based (salary) payments are usual, rather than fee-for-service and physician-determined fees still used by medicare and other third-party payers. Medicare can make use of competitive conditions in the health sector and such private sector developments to reform its physician payment policies through a variety of competitive, fee schedule, and integrated hospital-physician payment methods.

As the Nation's largest payer of health services, medicare also has many options for improving its assignment policies. One approach would be voluntary "participating physician" agreements where physicians would agree, for all their medicare patients, to

accept medicare's rates as payment in full except for coinsurance and deductibles. This model is already widely and successfully used by Blue Shield plans, with more than half of the Nation's physicians signing up for their "participating provider" contracts. Assignment rates can also be improved through expansion of mandatory assignment.

I. INTRODUCTION

Medicare consists of two separate programs: Hospital insurance (HI or part A), which provides coverage based on payment of social security taxes, and an optional supplementary medical insurance program (SMI or part B) in which the aged may enroll for a monthly premium at age 65. The SMI program is medicare's primary insurance for the aged against physicians service expenses; in 1984, an estimated 75 percent of SMI benefit payments will be for physicians services.

The major features of the SMI program are:

(A) *Enrollment.*—SMI enrollment is projected to be 29.3 million persons in 1984—26.6 million aged and 2.7 million disabled persons. About 69 percent of enrollees will receive program reimbursements for some services during the year.

(B) *Coverage.*—The program's benefits include physicians' services, outpatient, and other noninstitutional services not covered under the hospital insurance program. In order to be reimbursed, such services must be "reasonable and necessary" for diagnosis or treatment of an illness or injury; routine checkups and most preventive services are not covered. Prescription drugs are also not part of the program's benefits.

(C) *Premiums and cost sharing.*—The premium for enrollment is currently $14.60 per month, which covers about 25 percent of the program costs for the elderly (12 percent for the disabled); the rest of the costs are paid by general revenue appropriations to the SMI trust fund. Enrollees are responsible for a deductible of $75 per calendar year, plus 20 percent of the "reasonable charges" after this amount.

(D) *Reimbursement and assignment.*—The SMI program pays physicians what they ask to be paid for each service, unless that bill exceeds that physician's recognized "customary" charge or is higher than a "prevailing" charge maximum amount in an area. For each bill, a physician has the option to accept "assignment" of the bill, i.e., to bill the medicare program directly, accepting the program's reasonable charge determination as full payment (except for deductible and coinsurance). If the physician does not accept assignment of a bill, he or she bills the patient directly, and the patient then seeks reimbursement from the medicare program. For these "unassigned" bills, the beneficiary is liable for amounts billed by the physician which exceed medicare's determination of a reasonable charge, as well as the deductible and coinsurance. There are no limits on cost sharing for covered services or on amounts by which physicians charges may exceed the medicare reasonable charge levels.

The basic structure of the SMI program has changed little since the program was enacted. Nevertheless, two basic developments—the Federal budget deficit and a rapidly changing health care

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market—now provide reasons for a comprehensive review of the program, particularly its physician payment methods and assignment policies.

The Federal budget deficit.—The CBO baseline forecasts budget deficits of $195 billion in 1985, rising to $326 billion in 1989. Such deficits suggest the necessity for careful review of large and rapidly growing programs. With projected expenditures of $24.7 billion in 1985, SMI will be the third largest Federal domestic program—larger than medicaid, unemployment insurance, Federal civilian or military retirement, or food stamps—and exceeded only by social security and the medicare hospital insurance program. The growth rate of SMI outlays from 1984 to 1985—16.1 percent—is the highest of all these programs.

The rapidly changing health sector.—The Nation's health care system has grown and changed rapidly since medicare was enacted in 1965. National health spending rose more than eight times, from $42 billion in 1965 to an estimated $362 billion last year—and the physician supply rose more than 70 percent during this period. Many changes are now taking place in the private health sector, involving new ways of organizing and paying for hospital and physicians services. With medicare as the Nation's largest single payer for health services—an 18 percent market share—and physicians controlling 70 to 80 percent of health costs—the SMI physician payment policies have significant potential effects on the future of such developments.

As enacted, the SMI program reflected a balancing of various considerations to meet the needs of the elderly, taxpayers, and physicians. In reviewing its basic structures nearly two decades later, a number of policy questions will need to be considered in determining how best to address such needs for the years ahead. Such questions may include:

—What are the trends in physicians expenditures, both nationally and for medicare, and the reasons for those trends?

—What developments are taking place in the private health sector's organization, employment and payment systems for physicians services which may provide a model for considering new medicare policies?

—Should Federal payment policies shift from reimbursement to purchasing, from provider-determined rates to Government-determined rates?

—How can medicare, as the Nation's largest payer of physician services, contribute to development of competitive market forces and incentives to restrain health cost increases?

—Should medicare seek to protect the elderly and disabled against rising physician fees—or shift such costs to these groups in order to encourage more cost-conscious behavior?

—Are there ways that medicare's assignment rates can be improved to provide greater financial protection for the elderly?

The purpose of this paper it to provide background information and data for the consideration of such issues. Section II of the paper discusses trends in the market for physicians services. Section III discusses medicare physician reimbursement issues and assignment policies.

II. BACKGROUND

This section presents background data on:

—Trends in expenditures for physicians services, both nationally and for medicare, and factors which contribute to those developments.

—Organization and financial arrangements of physicians, particularly the growth of group practices and time-based payment arrangements (e.g., salaries) and the declining role of solo, fee-for-service practice.

—Income of physicians, its changes over time, and variations by specialty, age, and geographic area; and

—A summary comparison of the aged and nonaged in their use of physicians services.

A. Expenditures for Physicians Services

National expenditures for physicians services have been rising over the past two decades at increasing rates, from 8.3 percent annually in the 1960–65 period to a 14.9 percent annual rate in 1980–82, despite a recession. These trends of rising expenditures have also been reflected in medicare program spending for physicians services, which increased 15.8 percent annually from 1970–75, 18.6 percent annually from 1975–80, and 20.9 percent per year over the 1980–82 period. Nevertheless, medicare's rate of increase has been significantly greater than national average trends—and the difference has been widening. In the 1970–75 period, medicare spending for physicians services rose 4.1 percent per year faster than national spending; that difference increased to 5.2 percent per year in 1975–80 and 6 percent per year for 1980–82.

TABLE 1.—EXPENDITURES FOR PHYSICIANS SERVICES

[Dollars in billions]

	1965	1970	1975	1980	1982
Expenditures:					
National	$8.5	$14.3	$24.9	$46.8	$61.8
Medicare		$1.6	$3.3	$7.8	$11.4
	1960–65	1965–70	1970–75	1975–80	1980–82
Annual percent change:					
National	8.3	11.1	11.7	13.4	14.9
Medicare			15.8	18.6	20.9

Source: DHHS/HCFA, "Health Care Financing Review," March 1983, fall 1983. DHHS, "Health United States," 1982, p. 153.

B. Sources of Increase

A number of factors, such as population, inflation, and economic growth have an influence on health spending. Nevertheless, three major developments specific to the health sector also seem to have been factors in the national trends for physicians expenditures: (1) The rising supply of physicians; (2) growth of third-party payment for physicians services; and (3) rapid technological change. Some national data on these points is summarized in the following sections, followed by evidence from medicare actuarial analyses.

1. PHYSICIAN SUPPLY

The Nation's physician supply has risen very rapidly starting in the 1970's when joint Federal and private sector efforts to expand medical school enrollments began to bear fruit. The physician supply rose 40 percent in those 10 years alone, and nearly 30 percent more physicians are forecast by 1990. One result has been a much wider dispersion of physicians, so that most small towns under 2,500 population (according to Rand studies) are now served. The Graduate Medical Education National Advisory Committee (GMENAC) has forecast national oversupply of most physician specialties by 1990, and their calculations suggest that supply already exceeds need in many areas.

TABLE 2.—INCREASING PHYSICIAN SUPPLY

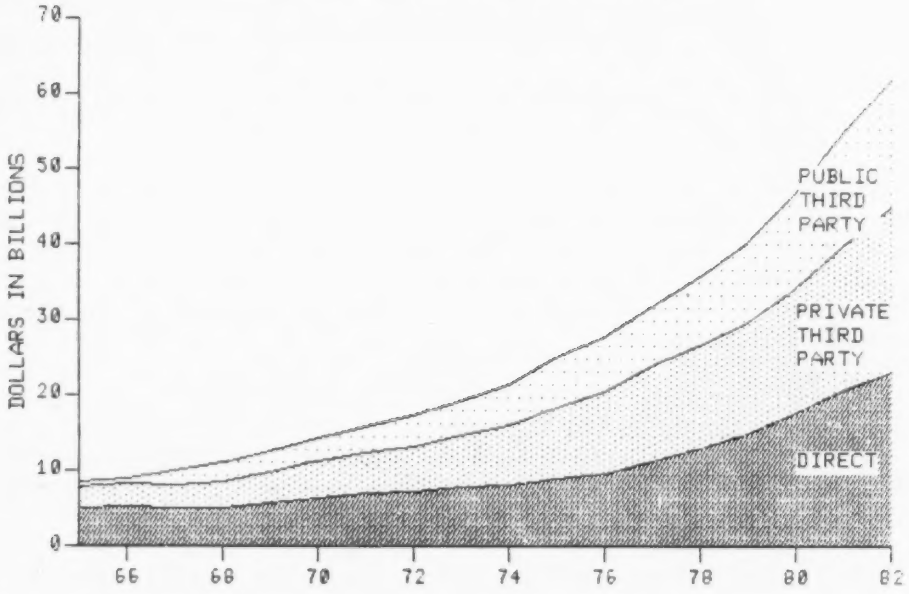
	1950	1960	1970	1980	1990	2000
Physicians	219,900	251,900	326,500	457,500	591,200	704,700
Per 100,000 population	141	136	156	197	243	271

Source: DHHS, "Health United States," 1982, p. 113.

2. THIRD-PARTY PAYMENTS

The increase in third-party payments for physicians services provides greater insurance protection against unnecessary bills. On the other hand, it may also encourage physicians to raise prices in expectation that patients will not object to such higher prices if they do not pay them directly, and it may lead to unnecessary use of some services. The portion of physicians bills paid directly by the patient has declined sharply from 83 percent of total spending in 1950 to 37 percent in 1982. The growth of public insurance, such as medicare and medicaid, and of private insurance have contributed about equally to this trend. The most rapid rise in third-party coverage came in the 1960's with the passage of medicare and medicaid, and the contribution of rising insurance coverage to physician expenditure trends, particularly in the private sector, slowed in the 1970's.

CHART 1
NATIONAL SPENDING FOR PHYSICIAN SERVICES
BY SOURCE OF FUNDS 1965-1982



Source: Health Care Financing Review, Fall, 1983

TABLE 3.—DIRECT AND THIRD-PARTY PAYMENT FOR PHYSICIANS SERVICES

[In percent]

Payment source	1950	1960	1970	1980	1982
Direct	83.2	65.4	45.1	38.0	37.3
Third party	16.8	34.6	54.9	62.0	62.7
Private	(11.7)	(28.2)	(34.0)	(35.3)	(35.2)
Public	(5.2)	(6.4)	(20.9)	(26.7)	(27.6)

Source: DHHS, "Health Care Financing Review," fall 1983.

3. SPECIALIZATION AND TECHNOLOGY

The Nation's physician supply has become increasingly more specialized, and medical care technology has changed rapidly with many new procedures being developed and adopted. Some of these new procedures, such as CT scanners, kidney transplants, and coronary artery bypass surgery, receive national attention, but most of the influence of technology must be inferred rather than measured directly. Between 1970 and 1980, for example, primary care physicians dropped from 44 percent of active non-Federal physicians to 39 percent, while specialists increased their central role in medical practice, from 56 to 61 percent.

TABLE 4.—ACTIVE NON-FEDERAL PHYSICIANS BY SPECIALTY

	1970		1980	
	Number	Percent	Number	Percent
Primary care physicians [1]	83,459	44.5	104,745	38.9
Other specialties	104,178	55.5	164,256	61.1

[1] General practice, internal medicine, pediatrics.

Source: DDHS, "Health United States," 1982, p. 114. Data are for physicians in office-based practice.

The rapid growth of new procedures is partly evidenced by the number of different procedure codes in the AMA's current procedure terminology. Between 1966 and 1978, the number of items tripled, from 2,084 to 6,132. In a survey conducted in 1982, 37 percent of office-based physicians said they had adopted one or more new procedures during the previous year. The adoption of new procedures in general and family practice, however, was half of this rate, reinforcing the impression of the linkage between specialization and technological change. Only 14 percent of physicians reported dropping procedures, and the most common reason for dropping a procedure (77 percent) was that it was replaced by a new one.

TABLE 5.—PERCENTAGE OF PHYSICIANS ADOPTING NEW PROCEDURES IN PREVIOUS YEAR, 1982

	Percent adopting new procedures	Percent dropping procedures
All physicians	37	14
Radiology	62	43
Surgery	46	15
Medical specialties	36	13
General/family practice	19	7
Ob/gyn	18	6

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, p. 24.

4. PRICING OF PHYSICIANS SERVICES

The physicians fee component of the Consumer Price Index provides an overall measure of physicians pricing decisions. Because of the changing nature of medical practice, the reported prices partly reflect new and replacement technologies and services. Based on this index, physicians decisions to raise their fees have been a significant factor in rising health costs. Fees rose faster than the overall CPI from 1967 to 1983, and the difference in inflation rates widened significantly in the 1980–83 period.

TABLE 6.—CONSUMER PRICE INDEX

	1967	1970	1975	1980	1983
CPI, all items	100.0	116.3	161.2	246.8	298.4
CPI, physicians services	100.0	121.4	169.4	269.3	352.3

Source: CEA "Economic Report of the President, 1984," p. 279. DHHS, "Health United States" 1982, p. 135 Conversation with BLS staff.

5. USE OF PHYSICIANS SERVICES

The potential importance of the nature of medical practice, rather than the number of physician visits, as a factor in rising physicians expenditures is also suggested by the fact that the per capita use of physicians services seems to have changed little over the past decade. Table 7 shows that physician visits per capita (including office, hospital outpatient, and telephone) remained almost unchanged from 1970 to 1980, and that there were moderate declines in both hospital discharges and days of care per 1,000 population.

TABLE 7.—NATIONAL PATTERNS OF HEALTH SERVICES USE

	1970	1975	1980
Physician visits (per person)	4.6	5.0	4.7
Hospital discharges (per 1,000)	145.9	124.4	120.0
Hospital days of care (per 1,000)	1,135	1,047	958

Source: DHHS "Health United States," 1982 pp. 90, 103. DHHS/HCF, "Health Care Financing Review," March 1983, p. 57. Conversation with NCHS staff.

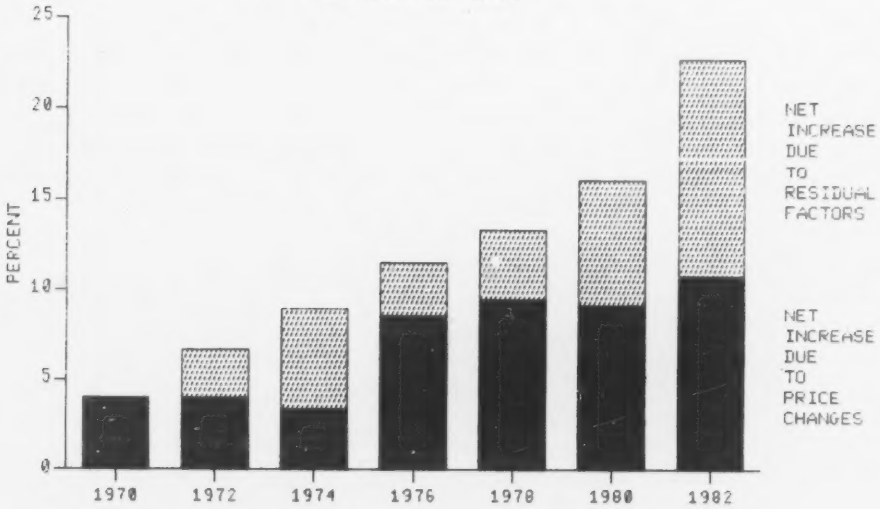
C. Sources of Rising Medicare Spending

National data on health services use and medicare actuarial studies indicate a similar pattern for the aged population as for the nonaged: Roughly level per capita use of visits and hospital days, but sharply rising costs resulting partly from physicians' pricing decisions and, more importantly, from rising volumes of separately billed services.

1. ACTUARIAL ANALYSES

The annual trustees report of the SMI fund provides historical analyses (and projections) concerning various factors affecting program costs. For physicians services, the analysis uses the CPI physician fee component as an indicator of price increases, with adjustment for effects of various "customary" and "prevailing" charge screens shown by program data. The remaining factors in cost increases—more services, more expensive services, effects of the deductible, etc.—are the residual between actual cost increases and what can be attributed to the pricing factors. More detailed information about the volume, type, and price of individual services paid for by the SMI program are not captured by the HCFA data systems; most of the available data is collected by bills (which include one or more services) or by claims (which include one or more bills). About 40 percent of SMI program increases thus are included in the "net residual" grouping.

CHART 2
COMPONENTS OF INCREASE IN RECOGNIZED CHARGES PER AGED ENROLLEE FOR PHYSICIAN SERVICES FOR SELECTED YEARS



Source. 1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund

TABLE 8.—COMPONENTS OF INCREASE IN RECOGNIZED CHARGES PER AGED ENROLLEE FOR PHYSICIANS SERVICES

[In percent]

Year ending June 30	Net increase due to price changes	Net increase due to residual factors	Total increase per aged enrollee
1970	3.9	0.1	4.1
1972	4.0	2.6	6.6
1974	3.4	5.5	8.9
1976	8.5	3.0	11.5
1978	9.4	3.9	13.3
1980	9.1	6.9	16.0
1982 (est.)	10.8	11.9	22.7

Source: "1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund," pp. 41, 44.

2. USE AND BILLING DATA

Various national survey and program data can supplement these aggregate allocations of program increases, although they are not adequate substitutes for data systems. As with the overall population, the volume of (nonhospital) physician visits per capita by the aged was roughly level from 1970 to 1980, and hospital use data reported by health interview surveys (an indicator for inhospital physician visits) declined slightly over the period. The number of hospital admissions per capita for the aged did increase about 25 percent over this period—but was offset by lower lengths of stay, possibly indicating more hospital use for relatively minor procedures.

TABLE 9.—HEALTH SERVICES UTILIZATION BY THE AGED

	1970	1975	1980
Physician visits (per aged)	6.3	6.6	6.4
Hospital days (per 1,000 aged)	3,075	3,007	2,772

Source: DHHS National Center for Health Statistics, Health Interview Data.

Despite the level pattern in indicators of health services use by the aged, SMI program data show that there were marked increases in the number of bills. While enrollment of the aged increased 26 percent during the 1970's, physicians' bills for services to them rose 220 percent. Bills from outpatient hospital services also rose—by 310 percent—over the decade, as did bills from independent laboratories—by 783 percent. The extent to which these data indicate more physician services are being provided per visit or during a hospital stay, or indicate changes in billing practices, e.g., "unbundling" or "bill-splitting," cannot be determined from the existing HCFA data system.

TABLE 10.—SMI ENROLLMENT AND PHYSICIAN BILLS—AGED

	1970	1980	Percent change
Enrollment (millions)	19.6	24.7	+26
SMI bills (millions)	40	137	+244
Physician (total)	33	105	+220
Medical	28	92	+229
Surgical	5	13	+170
Outpatient hospital	4	17	+310
Independent lab	1	6	+783

Source: DHHS, "Social Security Bulletin, Annual Statistical Supplement," 1982, pp. 205, 210.

D. Aged and Nonaged

Studies of the use of physicians services indicate that the aged have a closer and more satisfactory relationship with personal physicians than do the nonaged. Compared to the total population, the aged are more likely to have a regular source of care, to have seen a physician during the past year, to have seen him or her in an office visit and for more than a brief visit, and to be satisfied with the visit.

TABLE 11.—USE OF PHYSICIAN SERVICES—AGED AND NONAGED, 1980

	Total population	Over 65 population
Have regular source of care (percent)	89.2	93.1
Physician visits per year	4.7	6.4
Percent of visits in office or clinic rather than hospital outpatient department or telephone	67.1	75.7
Last physician visit within a year (percent)	75.0	79.4
Visit lasted 10 minutes or less (percent)	47.3	36.7
Return visit scheduled (percent)	58.0	71.3
Not at all satisfied with last doctor visit (percent) [1]	2.6	.9

[1] Robert Wood Johnson Foundation 1983 survey.

Source: DHHS, "Health United States," 1982, pp. 90–93.

E. Physician Income and Expenses

The 40 percent increase in physician supply during the last decade and generally flat per capita use of physician visits resulted in significant declines in workloads for physicians (132 visits per week in 1970 compared to 112 visits per week in 1980). Nevertheless, physicians in office-based practice were able to expand their net practice incomes and to maintain their income levels in real terms over much of the decade. As of 1982, such practice income was $99,500 and preliminary data for the first 6 months of 1983 indicate a further 10 percent rise last year. Improvements in real net income which occurred in the 1982 recession year were particularly notable, indicating the financial strength of the financing system for physician services. The reported income figures are pretax, exclude nonpractice income, and are net of tax deductible expenses.[1]

1. INCOME DISTRIBUTION

The distribution of these reported incomes shows a fairly large grouping of physicians around the mean income and a few physicians doing substantially better than the averages. Some 64 percent of physicians, for example, reported net practice incomes between $50,000 and $150,000, 5.4 percent between $200,000 and $300,000, and 1.6 percent above $300,000.

2. VARIATIONS BY SPECIALTY

Nevertheless, behind the income averages lies an economic picture which varies by specialty, geographic area, and age. Some physicians in some areas struggled to stay even or lost ground, others did extremely well. Primary care physicians, for example, started the 1970's with lower net incomes than other specialists and fell further behind over the decade. In 1970, for example, the income difference between a general practitioner and a general surgeon was $16,800; in 1982 the difference was $58,600.

TABLE 12.—AVERAGE NET INCOME FROM MEDICAL PRACTICE BY SPECIALTY

	1970	1980	1982	Percent change, 1970–82
All specialties	$41,800	$80,900	$99,500	+138
Primary care specialties:				
Internal medicine	40,300	79,100	86,800	+115
General practice	33,900	63,300	71,900	+112
Pediatrics	34,800	63,300	70,300	+102
Other specialties:				
Anesthesiology	39,400	94,900	131,400	+234
Surgery	50,700	98,600	130,500	+157
Ob/gyn	47,100	92,500	115,800	+146

Source: AMA "Socioeconomic Characteristics of Medical Practice" 1983, p. 118, and "Profiles of Medical Practice" 1981, p. 114.

[1] Data in this section, unless otherwise noted, refer to non-Federal office-based physicians, about 65 percent of all active physicians, and are based on AMA sampling. See AMA: "Socioeconomic Characteristics of Medical Practice 1983," Socioeconomic Reporting System Reports," and "Profiles of Medical Practice," various reports. The remaining 35 percent of physicians include primarily hospital-based physicians (residents (14 percent), full-time hospital staff (7 percent)), plus physicians with professional activities other than patient care (9 percent), and Federal physicians (4 percent).

3. VARIATIONS BY CENSUS AREA

The trends in physician income also differed significantly by geographic regions. Although there were exceptions, the regions with below average physician incomes continued to lose ground, and regions starting with higher income had faster income growth. These trends seem partly explainable by physician/population ratios. The Northeast and West had higher physician/population ratios (233.6 and 212.3 physicians per 100,000 in 1980) and lower incomes per physician, whereas the South and North Central regions (with 163.7 and 175 physicians per 100,000 population) had generally higher per physician incomes. Sun Belt migration may also have been a factor, e.g., the West South Central region, with the largest percentage increase in physician incomes, includes Texas, Oklahoma, Arkansas, and Lousiana.

TABLE 13.—TRENDS IN PHYSICIAN INCOME BY CENSUS REGION

Region	1973	1982	Percent Change
Middle Atlantic	$43,800	$91,100	+108
New England	44,200	82,200	+86
Mountain	47,400	95,800	+102
Pacific	48,100	92,900	+93
Average	48,600	99,500	+105
South Atlantic	50,300	97,900	+95
East North Central	50,500	106,200	+110
West North Central	51,500	106,500	+107
West South Central	52,800	118,700	+125
East South Central	53,300	106,800	+100

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, p. 118.

4. VARIATIONS BY AGE

Finally, a physician's age is also a factor in practice earnings. Yet even the youngest physician group, under age 35, earns some $73,000 annually; the peak earning years are 36 to 55.

TABLE 14.—PHYSICIAN NET INCOME BY AGE, 1982

Age group	Net practice income	Ratio to average
Less than 35	$73,300	0.74
36 to 45	108,200	1.09
46 to 55	116,500	1.17
56 to 65	99,500	1.00
66+	64,300	.65
Average	99,500	

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, p. 116.

The patterns of rising net physician income with age also suggest that behind the growth of the averages are significant age differences in economic experience. When physician net income is analyzed by age cohort, from 1974 to 1979, these underlying dynamics become apparent. Younger physicians, in fact, managed to expand

their incomes at substantially faster rates than older physicians. Whether this is due to technology—with younger physicians being trained in new surgical, diagnostic, or treatment techniques which older physicians have not mastered—or some combination of other factors cannot be determined from these data. As with the variations due to other causes, however, it is clear that different pictures of economic experience can be drawn depending on specialty, region, or age—and that generalizations about physician practice should recognize these qualifications.

TABLE 15.—PHYSICIAN NET INCOME BY AGE COHORT

1974		1979		Percent change
Age group	Income	Age group	Income	
Less than 35	$38,336	36 to 40	$83,900	+118.9
36 to 40	55,140	41 to 45	91,300	+65.6
41 to 45	59,002	46 to 50	87,700	+48.6
46 to 50	57,705	51 to 60	82,800	+43.5

Source: AMA, "Profile of Medical Practice," annual editions.

5. DETAIL OF PRACTICE EXPENSES

The net practice incomes cited in the above estimates reflect gross physician earnings, which are nearly 80 percent higher than net earnings ($178,000 in 1982 versus $99,500 in net earnings), offset by tax-deductible practice expenses. In 1982, these tax deductible expenses came to $78,400 per physician. These deductions varied significantly by specialty, with surgery and obstetrics/gynecology having the highest practice expenses. Over the 1970–82 period, basic practice expenses grew more slowly than other tax-deductible expenses.

TABLE 16.—INCREASES IN TAX-DEDUCTIBLE PRACTICE EXPENSES

	1970	1982	Percent change
Basic expenses [1]	$22,000	$66,400	+202
Other expenses [2]	2,500	12,000	+380
Total	24,500	78,400	+220

[1] Basic expenses: Nonphysician payroll, office expenses, medical supplies, professional liability insurance, and medical equipment.
[2] Other expenses: Professional automobile, professional development, and other (e.g., contribution to tax-deferred compensation program).

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, pp. 110, 114, and "Profiles in Medical Practice" 1981.

F. New Organization and Financing Arrangements

When medicare was enacted and its payment policies established, most physicians were in private office-based practice and paid on a fee-for-service basis. With rapid changes in the past few years, this is no longer the case. Most physicians are now members of a group practice, and more than half now receive at least part of their income on a time-related basis, such as a salary. New organizations are also being established which link hospitals and physicians in a common financial and management structure, such as preferred provider organizations (PPO's), health maintenance organizations

(HMO's) and independent practice associations (IPA's). Such developments suggest new patterns for reimbursement policies.

1. GROUP PRACTICE

By 1983, group practice arrangements had increased to include a 51 percent majority of office-based physicians, compared to 46 percent in 1975. The average size of groups also increased during this period, with a relative decline in two-person groups and the largest percentage increases in groups from 8 to 25 members and from 5 to 7 members.

TABLE 17.—DISTRIBUTION OF PHYSICIANS BY SIZE OF PRACTICE

Size of practice, number of physicians	Percent of physicians	
	1975	1983
Solo	54.2	48.9
Group	45.8	51.1
2	(14.1)	(12.5)
3 to 4	(15.0)	(15.7)
5 to 7	(6.3)	(8.6)
8 to 25	(6.0)	(8.8)
26+	(4.5)	(5.3)

Source: AMA, "Socioeconomic Monitoring System Report," November 1983.

Within the group practices, practice incomes were distributed by a number of arrangements. Most importantly, however, 52 percent of group practice physicians reported being paid on a salary basis, while only 34 percent had income based on the fees charged for their services. Thus, while bills are still submitted on a fee-for-service basis, most group practice physicians are paid on a time-related basis. In part, this is a function of age of the physician: 58 percent of physicians under age 36 in group practice are paid on a salary basis while the majority of those over the age of 56 are paid fee for service, percentage of gross, or net billings, or some other arrangement. An analogy could be drawn with law firms, which evolved from solo practitioners charging separately for their services to law firms of groups of lawyers where most billings are on an hourly basis. In such firms, as well, it is also conventional practice for younger lawyers to be paid on a salary basis while those who established the practice and partners may have other nonsalary arrangements.

TABLE 18.—METHODS OF PRACTICE INCOME DISTRIBUTION FOR NONSOLO PHYSICIANS, 1983

[In percent]

	Fee for service	Salary	Percentage of net/gross billings	Other
All physicians	34	52	11	3
Specialty:				
General/family	41	43	14	2
Surgical specialist	37	49	11	3
Other specialist	32	55	9	5
Medical specialist	31	56	10	3
Physician age:				
Less than 36	26	58	12	4

TABLE 18.—METHODS OF PRACTICE INCOME DISTRIBUTION FOR NONSOLO PHYSICIANS, 1983—Continued

[In percent]

	Fee for service	Salary	Percentage of net/gross billings	Other
36 to 45	34	52	11	3
46 to 55	36	50	9	4
56+	39	48	11	2

Source: AMA, "Socioeconomic Monitoring System Report," November 1983.

2. HOSPITAL-PHYSICIAN ARRANGEMENTS

A significant proportion of physicians—26 percent—have financial arrangements with hospitals. For these physicians, such arrangements are an important source of income—providing 62 percent of their net practice incomes. While such arrangements are not unusual for such hospital-based specialties as pathology and radiology, internal medicine—the speciality with the largest share of medicare reimbursements (21 percent)—also shows more than one-third (36 percent) of that specialty already entering into financial arrangements with hospitals. Internists with such arrangements received 40 percent of their income from this source.

TABLE 19.—PHYSICIANS FINANCIAL ARRANGEMENTS WITH HOSPITALS

Specialty	Percent with financial arrangements	Percent net income from arrangement
All physicians	26	62
Pathology	78	96
Radiology	58	80
Internal medicine	36	40
Psychiatry	32	56
Anesthesiology	27	87
Pediatrics	17	69
General/family practice	14	40

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, pp. 12, 13.

These hospital-physician contracts are strikingly similar to the arrangements made within group practices when physicians decide on how to pay themselves and their colleagues. A reported 59 percent of the arrangements are based on salary, compared to 33 percent based on fee for service. (Within groups, financial arrangements average 52 percent salary and 34 percent fee for service.) The specialties where such salary arrangements are more usual include internal medicine, general/family medicine, and surgery—the three specialties accounting for the highest share (44 percent) of medicare physician payments.

TABLE 20.—TYPE OF CONTRACT FOR HOSPITAL ARRANGEMENTS[1]

[In percent]

Specialty	Salary	Fee for service	Percent of net/gross billings	Other
All physicians	59	33	11	27
Psychiatry	87	16	9	24
Surgery	68	29	11	46
General/family medicine	60	27	13	19
Internal medicine	58	45	4	22
Pathology	53	21	24	19
Radiology	30	57	15	24

[1] Totals may exceed 100 percent because some physicians have more than one arrangement. The most frequent "other" arrangements include bonuses, leases, and a minimum guaranteed income.

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, p. 14.

The close financial linkage of hospitals and physicians is also indicated by the fact that 17 percent of physicians now report that they are associated with hospital departments which are closed to new appointments. Such closures—which may raise significant antitrust issues—were reported most prevalent in the Northeast and West, regions with the highest physician/population concentrations.

TABLE 21.—*Hospital departments closed to new appointments*

	Percent
All physicians	17.4
Specialty:	
Medical specialties	22.4
Surgical specialties	17.8
Other specialties	20.2
General/family practice	6.4
Region:	
Northeast	23.6
West	16.7
South	15.9
North Central	15.2

Source: AMA, "Socioeconomic Characteristics of Medical Practice," 1983, p. 33.

3. PROFESSIONAL CORPORATIONS

In 1983, a majority of physicians—54 percent—reported being in professional corporations. The trend toward incorporation—a 23 percent increase from 1975 to 1983 (31 to 54 percent)—was even stronger than the trend toward group practice, which showed a 5 percent increase (46 to 51 percent) over the same period.

TABLE 22.—PHYSICIANS IN PROFESSIONAL CORPORATIONS

[In percent]

	1975	1983
All physicians	31	54
Specialty:		
Surgical specialties	48	64
Other specialties	43	60
Medical specialties	33	47
General/family practice	24	39

Source: AMA, "Socioeconomic Monitoring System Report," November 1983.

4. EMPLOYMENT STATUS

In 1983, most physicians (77 percent) reported themselves to be self-employed. Nevertheless, nearly one-quarter of physicians—23 percent—were employed by others, most often by hospitals (9 percent) or other employers such as HMO's (12 percent). Physicians under the age of 36 were far more likely to become an employee—and to be an employee of one of these "other" employers—than were older physicians.

TABLE 23.—PHYSICIANS EMPLOYMENT STATUS BY AGE, 1983

[In percent]

Physician age	Self-employed	Hospital employee	Government employee	Other employee
All physicians	77	9	2	12
Less than 36	61	11	2	26
36 to 45	77	10	3	10
46 to 55	80	8	3	9
56+	81	7	2	10

Source: AMA, "Socioeconomic Monitoring System Report," November 1983.

III. REFORM ISSUES AND OPTIONS

The previous section described several major developments in the health system since medicare was enacted. These developments include: (1) A third-party reimbursement system, based on fee-for-service reimbursement, which has combined with rising physician supply and new technology to accelerate spending for physicians services, particularly for medicare; (2) a transition from solo office practice to group practices, contracts with hospitals, and employment arrangements; (3) a corresponding development—within the health sector—of time-based (salary) physician compensation rather than the fee for service used for billing patients and third-party payers, such as medicare. The following sections discuss medicare's current policies for physician reimbursement and assignment policies in light of these general developments and the specific characteristics of the medicare program.

A. Reimbursement Policy

1. HISTORY

Prior to enactment of medicare, most private insurance payments to physicians were determined by fee schedules established by the insurance company. In establishing legislative policies for medicare's physician payments, however, the Social Security Admendments of 1965 adopted, as a legislative compromise, the "usual, customary, and reasonable" (UCR) reimbursement approach used by some Blue Shield plans which paid physicians what they asked to be paid so long as that amount was not higher than they usually charged, or unreasonable in relation to what other physicians in their area were billing for the same service. This approach, presumed to be neutral in its effects on physicians fees and medical practices, was more attractive to physicians than Government-determined fee schedules and allowed the elderly to select their physicians with high confidence that medicare would cover most of the bill. The statute provided that the program would be administered primarily through existing insurance carriers; section 1842 of title XVIII required these insurance carriers to:

> Assure that, where payment * * * is on a charge basis * * * such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier * * * In determining the reasonable charge * * * there shall be taken into consideration the customary charges for similar services generally made by the physicians * * * as well as the prevailing charges in the locality for similar services.

In contrast to fee schedules, where payments are the same for all providers, the UCR method recognizes a range of fees in an area for each service. Following enactment of medicare, the UCR approach was adopted generally by Blue Shield plans (which administered most of the SMI program) as the standard for their private business.[1] Rather than simply being "neutral" with respect to market prices for physician services and medical practice, as intended, the medicare policies thus had far-reaching consequences for physician payment methods and economics of physician practices.

2. CURRENT POLICY

As the medicare program developed, the reimbursement practices of individual carriers have become more subject to standardized policies and procedures—and far more complex in dealing with a wide variety of situations and issues—but the basic approach has remained the same as in the original statute. Medicare's reimbursement for most physicians services are based on a variant of the Blue Shield UCR approach called "customary, prevailing and reasonable" (CPR or, sometimes, RCP) reimbursement.

Under the medicare method, each physician's bill is compared against two fee limits: The physician's recognized "customary" charge for the service and "prevailing" maximum charges which are allowed for that service in a particular area. If the bill does not exceeds one or the other of these limits, it is recognized as "reasonable" and payable in full (except for the deductible and 20 percent copayment). If the bill exceed one or the other of these limits, the amount recognized is the maximum allowed by the limits. Carriers retain a great deal of discretion in such issues as determining the "localities" for which separate fee determinations are made, in billing terminology and definition of services, and in recognition of specialist/nonspecialist charges for the same services.

The prevailing charge limits were originally determined by the 90th percentile of the distribution of customary charges in each locality, providing covered reimbursement for all but the highest 10 percent of physicians charges. This screen was tightened to the 83d percentile in 1969 and later reduced, starting in 1971, to the 75th percentile of customary charges made during the prior year. In the 1972 amendments (which were not, however, implemented until 1976), Congress provided that prevailing charges were to be increased only by an index reflecting practice costs and general wage increases. Over time, it was anticipated that customary charges would probably increase faster than this index so that these "indexed prevailing" rates would eventually become a medicare fee schedule.

Finally, for reasons of program administration and to restrain costs, the customary and prevailing charge screens are only updated once a year, based upon the prior year's history of physicians services. Thus the screens are often a year or more behind current physicians fees.

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elbanco, T. L., Meyers, C. C., Segal, E. A. "Paying the Physician's Fees: Blue Shield and the Reasonable Charge." N Engl J Med. 1979; 301:1314-1320.

3. CRITIQUES OF CURRENT POLICIES

(a) Incentives for Appropriate Medical Care

One of the major critiques of medicare's reimbursements is that they are not neutral with respect to physicians decisions about appropriate medical practice. In particular, studies indicate that current payment rates result in incentives for hospitalization and surgical procedures rather than for less expensive settings or treatment choices. Such incentives have implications for medicare's hospital costs, since physicians control the decisions about whether or not to hospitalize patients, testing, treatment, and lengths of stay.

For many illnesses, there are a range of treatment methods—particularly involving different utilization of hospitals and surgical procedures—which are consistent with accepted medical care. Health maintenance organizations, for example, produce most of their savings by substantially less use of hospital care, which is partly offset by greater use of ambulatory services. In a review article on elective surgery, for example, Wennberg, Bunker & Barnes found per capita rates of elective surgery vary up to 6:1 within U.S. service areas studied.

TABLE 24.—SURGICAL PROCEDURE RATES PER CAPITA IN VARIOUS GEOGRAPHIC AREAS, 1975

Procedure	SOSSUS areas [1]		Maine and Vermont hospital service areas		Ratio high to low
	Low	High	Low	High	
Hysterectomy	0.59	1.26	0.49	1.43	2.92
Tonsillectomy	.79	2.06	.33	1.83	6.24
Inguinal hernia	.81	1.16	.69	1.19	1.72
Cholecystectomy	.48	.90	.67	1.57	3.27
Appendectomy	.67	1.13	.40	1.40	3.50
Prostatectomy	.46	.85	.54	1.92	4.17
Hemorrhoidectomy	.60	.80	.20	1.00	5.00

[1] SOSSUS: "Study on Surgical Services for the United States," American College of Surgeons, 1975. Areas are States or major metropolitan areas.

Source: From Wennberg, Bunker, Barnes, "The Need for Assessing the Outcome of Common Medical Practices" in Annual Review of Public Health. Annual Reviews, Inc., 1980. 1:277-95. Rates expressed as ratios to U.S. national rates, 1975.

A similar study of cataract operations in Maine (also by Wennberg) relates such variations in hospital/surgical procedures to medicare's part B reimbursements. In this study the part B reimbursements per enrollee for cataract operations varied by a ratio of 6.9:1 among service areas. Wennberg's analysis indicates that 92 percent of the variation in per capita reimbursements could be accounted for by variations in procedures rates; variations in reimbursements per case could account for only 22 percent of the variation.[2]

The extent to which medicare and other reimbursement methods overpay physicians for surgical services has been assessed in a landmark study by Hsaio and Stason. Their study indicates that, even after standardizing for complexity, physicians are paid 4 to 5

[2] Wennberg, J. E., Jaffe, R., Sola, L. "Some Use of Claims Data for the Analysis of Surgical Practices." DHHS New Challenges for Vital & Health Records, PHS #81-1214, December 1980.

times as much per hour for hospital-based surgery as for office visits, e.g., $200 per hour versus $40 per hour in 1978.[3]

The medicare payment differentials between hospital and office-based care also extend to nonsurgical services. As reflected in the following medicare data, such differentials are 18 to 32 percent greater for hospital than for office visits.

TABLE 25.—MEDICARE WEIGHTED MEAN PREVAILING CHARGES, HOSPITAL/OFFICE LOCATIONS, 1982

Service	Hospital	Office	Ratio
Initial comprehensive visit:			
Specialist	$68.38	$52.09	1.31
General practitioner	52.43	39.75	1.32
Brief followup visit:			
Specialist	19.85	15.81	1.26
General practitioner	14.62	11.78	1.24
Limited followup visit:			
Specialist	20.56	17.41	1.18
General practitioner	17.21	14.30	1.20

Source: "Background Data on Physician Reimbursement Under Medicare," S. Prt. 98-106, October 1983, p. 76. Cited hereafter as S. Prt. 98-106, October 1983. Data in above table from HCFA, unpublished tables.

The combination of these higher payment rates—and the ability to see more patients in a given time period in hospital rounds than in the office—mean that hospital-based care produces higher revenues per hour for most physician specialties. Internists, for example, have been shown to earn 2 times more per hour for hospital visits compared to office visits; ratios for other specialties were 1.16:1 to 2.01:1.[4]

Hospital-based care also reduces a physician's own overhead expenses, since equipment, supplies, support personnel, etc., are provided without charge to the physician by the hospital; in an office setting such costs would more likely be a physician's expense. (Physicians may have some added costs for hospital care, however, if additional travel time is required.) These incentives create a situation in which medicare's reimbursement rates (and those of other UCR payers) do not appear neutral with respect to medical decisions about appropriate medical care and may result in added program costs.

(b) Payment of New Procedures

Other concerns about medicare's payment policies reflect their treatment of new procedures and technologies. Medicare's fee-for-service approach offers separate fees for separately identifiable procedures or services. Such fee-for-service payments may encourage the adoption and use of new or add-on technology and services and may have been a factor in the tripling of separately billable procedures from 1966 to 1978 and in medicare's 248 percent rise in SMI bills from 1970 to 1980.

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[3] Hsiao, W. C., Stason, W. B. "Toward Developing a Relative Value Scale for Medical and Surgical Services." Health Care Financing Review. Fall 1979; 1(2); 23-38.

[4] Blumberg, M. S. "Rational Provider Prices: Provider Price Changes for Improved Health Care Use" in Health Handbook ed. George Chacko, North Holland 1979. Data cited in Enthoven, A., Health Plan, Addison-Wesley, 1980, p. 22.

The "customary" and "prevailing" charges for new procedures and technologies are usually established when they first become part of accepted medical practice and may still be expensive and difficult. Nevertheless, the CPR method continues to recognize such fees even as a procedure becomes routinized and costs fall with experience and volume. One example of this pattern is coronary artery bypass surgery, a procedure initially recognized for payment when lack of experience with the procedure required exceptional time commitment by the surgeon, including diagnosis and postoperative care. The procedure now requires about 2 to 4 hours of the cardiac surgeon's time, with other care delegated to residents and others. Nevertheless, the medicare surgeon's fees have not adjusted downward. Writing in the New England Journal of Medicine, Dr. Benson Roe estimated that performing an average of less than three coronary artery bypass operations per week produced annual incomes of at least $350,000 apiece for the 700 cardiac surgeons performing the procedure in 1979.[5] Many similar payment decisions will face medicare in the future as a wide range of new and expensive technologies and procedures enter medical practice and become acceptable for diagnosis and treatment.

(c) Generalist Versus Specialist

The medicare CPR system also allows higher payments when the same services are performed by a specialist than by a nonspecialist. For the five most common services provided by both specialists and nonspecialists (which are simply visits undefined by time or content), specialist reimbursements averaged 19 to 53 percent greater than nonspecialists.

TABLE 26.—MEDICARE WEIGHTED MEAN PREVAILING CHARGES, SPECIALIST/NONSPECIALIST, 1982

	General Practitioner	Specialist	Ratio
Brief followup hospital visit	$14.62	$19.85	1.36
Brief followup office visit	11.78	15.81	1.34
Limited followup hospital visit	17.21	20.56	1.19
Limited followup office visit	14.30	17.41	1.22
Minimal followup office visit	14.56	22.28	1.53

Source: S. Prt. 98-106, October 1983, citing DHHS/HCFA, unpublished data.

The appropriateness of these differentials has been questioned on grounds of fairness and of impact on physician specialty decisions. The determination of which physicians are (or are not) specialists in a particular medical field is not a simple matter and is left to individual carrier determinations. In 1980, for example, 48.7 percent of non-Federal physicians were not board-certified in their field of specialization.[6] Similarly, it is also difficult to determine whether care provided by a specialist was general medical care or services requiring specialist attention. An estimated 20 percent of

[5] Roe, B. B. "The UCR Boondoggle: A Dealth Knell for Private Practice?" N Engl J Med. 1981; 305:41-5.

[6] Bidese C., Danais, D. "Physician Characteristics and Distribution in the U.S." 1981 AMA.

patients, for example, receive continuing general medical care from a specialist physician.[7]

A second reason for concern reflects the view that the Nation needs more primary care physicians and, conversely (as shown by the GMENAC report) many of the higher paid specialists are (or soon will be) in oversupply. Nevertheless, the higher payment differentials paid by third-party payers using UCR/CPR reimbursement not only are expanding the incomes of such specialists at a substantially higher rate than for primary care physicians (as shown in the background data) but may also be affecting, in turn, medical schools—which now depend on service income for 30 percent of budgets compared to 12 percent 10 years ago—in their economic choices about supporting residency programs, and students—with increasing debt levels to finance their education—in their decisions concerning primary care or other specialties.[8]

(d) Urban Vers 's Rural

Medicare's policies result in recognizing different "prevailing" charge levels by geographic areas. Such differences have been questioned both on grounds of equity (should physicians in some areas be paid less than their colleagues in other areas for the same service?) and policy (are the current incentives to practice in urban areas desirable in view of the greater physician shortage in rural areas?). A study by Burney, Schieber et al., showed that prevailing charges are 23 percent higher in metropolitan than nonmetropolitan areas, a greater differential than justified by cost-of-living differences.[9] On a locality by locality basis, the fee differences are much larger, and the differences appear to be widening rapidly.

TABLE 27.—HIGH AND LOW PREVAILING MEDICARE CHARGES

Procedure/fee screen year	High	Low	Ratio
Brief followup visit by an internist:			
1976	$18.18	$6.70	2.71:1
1980	33.10	7.00	4.73:1
Extraction of lens by an opthalmologist:			
1976	900.00	412.56	2.18:1
1980	1,390.70	536.50	2.59:1
Electrosection of prostate by a urologist:			
1976	862.70	356.46	2.42:1
1980	1,410.40	475.25	2.97:1
Hysterectomy by an obstetrician/gynecologist:			
1976	850.00	400.00	2.13:1
1980	1,305.20	536.50	2.43:1
Chest X-ray single view by a radiologist:			
1976	25.00	4.00	6.25:1
1980	35.00	5.50	6.36:1

Source: HCFA, "Medicare Part B Charges, Overview and Trends, Fee Screen Years, 1976-80," Feb. 3, 1982, p. 44-48. Reprinted in S. Prt. 98-106, pp. 73-74.

[7] Mendenhall, R. C. "Medical Practice in the United States." Robert Wood Johnson Foundation, 1981.

[8] JAMA, Sept. 23-30, 1983; 250:12-1527.

[9] Burney, I. L., Schieber, G. J., Blaxall M. O., Gable, J. R. "Geographic Variation in Physicians Fees. JAMA 1978; 240: 1368-1371.

(e) Excessive Costs and Inadequate Insurance Protection

Medicare's "customary" and "prevailing" screen approach to limiting payments has also been questioned on several grounds. Rather than disallowing charges which are substantially different from normal bills, the screens now operate to reduce charges on most bills. Based on projecting recent experience, 85 to 90 percent of medicare physician bills will be partially disallowed this year, with the amount determined to be unreasonable averaging about 25 percent of the bill and the aged responsible for the disallowance averaging $35 to $40 per bill. As many of the aged have learned, most private medigap insurance policies do not cover such disallowances.

TABLE 28.—REASONABLE CHARGE REDUCTIONS FOR MEDICARE PART B [1]

	1974	1976	1978	1980	1982
Percent of claims reduced:					
Assigned	61.0	73.1	73.4	80.0	83.1
Unassigned	70.6	78.4	77.2	83.7	85.6
Percent reduction in charges for covered services:					
Assigned	13.0	19.0	19.8	22.5	24.3
Unassigned	13.6	18.8	19.1	22.3	24.1
Amount reduced per approved claim:					
Assigned	$8.24	$13.74	$16.11	$21.81	$29.32
Unassigned	$10.44	$15.75	$16.76	$21.96	$28.10

[1] Excludes claims from hospital-based physicians and group practice plans. Texas Blue Shield excluded from 1982 data.

Source: DHHS/HCFA, "Part B Reasonable Charges and Denial Activity Report," fiscal year 1982, August 1983. Reprinted in S. Prt. 98-106, October 1983, p. 32.

There are several major difficulties with these screens. First, they are obviously not working very well to contain program costs for the taxpayer and beneficiaries. Medicare physician expenses have been accelerating for the past 15 years. For the aged, the fee screens function to reduce medicare's effective insurance protection, even as premiums are increased. Nor can it be particularly satisfactory to physicians to have 85 to 90 percent of their medicare bills determined to be "unreasonable" charges.

There are particular problems with the "customary" charge screens, which are updated after a fee has been charged for a year. They result in no long-term cost control since they escalate with physicians charges, albeit with a delay. For physicians bills which arrive between updates, if they reflect any increase at all, e.g., for CPI inflation, they are determined to be an "unreasonable" charge and partially denied. Such an "unreasonable" determination is applied even if the physician's fee is below amounts which many of his or her colleagues are receiving for the same service with no disallowance. These results raise issues of equity, both for the physician involved and his or her patients responsible for the disallowed charges.

The "indexed prevailing" charge limits have effectively locked in most of the payment differentials, by service, specialty, and location, which existed in 1973. From national medicare data it is not possible to determine how close the SMI program already is to a de facto "fee schedule." A 1980 Urban Institute study of California medicare bills showed a variable pattern; customary charges were

greater than the "indexed prevailing" for 99.7 percent of basic anesthesiology, 44 to 88 percent for four listed surgical procedures, and 30 to 50 percent for a number of other services.[10] Such variations raise questions concerning the appropriateness and equity of the prevailing maximums—and about the degree of insurance protection actually provided for the elderly for different services.

4. REFORM OPTIONS

There are a wide range of potential options for reforming medicare's physician payment policies, incorporating various competitive market mechanisms, fee-schedule, salary, and capitation arrangements and integrated systems of organizing and financing medical care (HMO's, PPO's) already employed in the United States and abroad. The following sections discuss rationales and medicare background data as they relate to three of these possible approaches: (1) Competitive purchasing for physician services; (2) fee schedules; and (3) integration of hospital and physician payments for inpatient physician services. Such reform strategies could be used separately or together.

(a) Competitive Approaches

Medicare pays physicians primarily on the basis of what they ask to be paid (or asked to be paid in 1973, adjusted for the prevailing charge index) rather than on the basis of the best price which could be obtained for the taxpayer and the aged by competitive purchasing. The reasoning that medicare should be able to achieve substantial discounts below its present rates rests on considerations of its market share, physician oversupply, and demonstrations of this approach in the private sector.

First, the size of medicare's purchasing power in the physician services market—$18 billion—will represent 18 percent of physicians incomes in 1985; for individual procedures, e.g., cataract operations, and/or areas, e.g., Florida, medicare represents an even larger share of the market. With such purchasing power, simply accepting whatever physicians decide to charge makes little sense. Certainly a private business with such market power would be unlikely to let its suppliers dictate prices.

Second, the rapidly rising physician supply (and oversupply) creates favorable conditions for market-based approaches, Physician prices and incomes, which might have fallen in vigorously price-competitive markets, have continued to rise as permitted by third-party UCR reimbursement practices, and income rises have been particularly rapid in specialties, such as surgery, where there is the greatest oversupply (but also the greatest insurance coverage). A shift in medicare payment policies from reimbursement to competitive purchasing could thus be timely and effective.

Finally, there are a number of private sector initiatives aimed at strengthening competitive market forces in the physician market in order to restrain costs, primarily various forms of preferred pro-

[10] Paringer, L. "The Effect of the Medicare Economic Index on Reasonable Fees; Evidence From California." Urban Institute working paper 1306-01-04, July 1981, p. 14. Cited in S. Prt. 98-106, October 1983, p. 46.

vider organizations (PPO's) which shift business to lower cost providers. As yet, there is still inadequate experience to say how well various approaches will work. Nevertheless, such developments may provide successful models for the medicare program to save money both for the taxpayers and the aged.

One approach to competitive purchasing on behalf of the aged would be to select certain procedures and areas characterized by: (1) High medicare market share; and (2) a surplus of qualified physicians able to provide such services. Medicare could invite bids from physicians for the specified services, with the proviso that the physicians would accept assignment for all medicare patients. Lower bids would be accepted; these physicians and their prices could be made known to the aged and other physicians, perhaps with reduced cost sharing.

A competitive approach could also be initiated by establishing specific discounted prices which a physician would have to meet in order to be a participating provider or continue in the program, e.g., fees no greater than 10 percent below the average of customary charges. Negotiated fees could also be developed for specialty service, particularly where limiting the number of medicare providers would improve quality of care for the elderly, e.g., eliminating low volume providers of open heart surgery with high surgical mortality rates. Finally, the SMI claims processing franchise could also be competed based on a company's ability to achieve savings through such competitive measures, with the carriers placed at risk for cost overruns.

(b) Fee Schedules

A second reform would replace medicare's CPR reimbursement method with Government-established fee schedules. This approach would be consistent with the medicare hospital reforms, approved by Congress last year, which establish a single price for the same service in each area, rather than paying different providers widely different amounts for the same service. The adoption of a fee schedule would also represent a logical extension of the prevailing charge fee schedules and index formula adopted in the 1972 amendments and in use for the past 8 years. A recent CBO report estimated savings of $8.1 billion over the next 5 years if such an approach were adopted with fees averaging 5 percent below projected levels.

The development of fee schedules would provide a way to address all of the major issues of medicare's current reimbursement methods: Inpatient versus outpatient, surgery versus office care; generalist versus specialist; urban versus rural; appropriate pricing of new technology; control of costs; equity among physicians in an area, and administrative simplicity. One reform direction, consistent with developments in private sector payment arrangements, would move from procedure-by-procedure fees toward a more time-related basis for reimbursement, as exists for other professionals such as lawyers. Under such an approach, many separate fees might be replaced by a simplified basic time rate (with some adjustments for unusual costs)—recognizing that effort spent in diagnosis and counseling can be as valuable a part of medical care as per-

forming surgical or other procedures. As discussed earlier, 52 percent of members of group practices and 59 percent of office-based physicians with hospital arrangements are already compensated on a salary basis, as well as physician employees of HMO's, hospitals, and Government.

A second approach to developing fee schedules would be to make greater use of fees for defined groups of related services in treatment of an illness. Such developments would parallel the Congress hospital reimbursement reforms which provided a single diagnosis-based payment for all hospital costs related to a hospital admission. Such "global" fees are now sometimes in use, e.g., for reimbursement of an ophthalmologist for cataract operation and followup checks, but are not required.

This approach could make a major contribution to constraining the rising volume of billed services and costs. It would also recognize that most medicare claims are part of a related series of visits and services. For aged persons who received SMI benefits, medicare paid for an average of 21 physician bills in 1978, and 72 percent of physician office visits by the elderly (in 1980) resulted in scheduling of a followup visit.[11] Of the 15 medicare services most frequently provided both by generalists and specialists, nine were some form of "followup" visit.

TABLE 29.—*Frequency of medicare procedures, fee screen year 1982*

Procedure:	*Frequency (millions)*
Brief followup hospital visit	42.2
Brief followup office visit	22.1
Limited followup hospital visit	16.8
Limited followup office visit	15.2
Minimal followup office visit	14.5
Intermediate followup office visit	11.5
Intermediate followup hospital visit	9.9
Chiropractic office visit	8.8
Electrocardiogram (EKG)	6.5
Initial limited office visit	5.7
Initial brief hospital visit	5.3
Extended followup office visit	4.6
Electrocardiogram (EKG)-interpretation report only	4.4
Brief followup nursing home visit	3.8
Initial comprehensive hospital visit	2.5

Source: DHHS/HCFA, unpublished data. Cited in "Background Data on Physician Reimbursement Under Medicare," S. Prt. 98-106, October 1983, p. 75.

(c) Integration of Hospital and Physician Payments for Inpatient Services

A third potential reimbursement reform is integration of hospital and physician payments for inpatient hospital services, which are 60 percent of medicare physician reimbursements. Three reasons suggest such a reform effort. First, inpatient physician fees are the most expensive for the aged and the medicare program; such integration would allow them to be controlled along with the hospital payment. Second, the reform would give physicians—who make most of the decisions concerning medical care—a financial

[11] McMillian, A. Pine, P., Newton, M. "Medicare: Use of Physicians Services Under the Supplementary Medical Insurance Program, 1975-1978." HCFA 03151, March 1983 p. 79. Cited in S. Prt. 98-106, October 1983, p. 54.

stake in their medical decisions; excess use of resources could result in lowering their own payments. Finally, such a development could set up an important competitive dynamic to constrain costs—with the potential of hospitals taking advantage of the oversupply of physicians in their area, e.g., surgeons, by having some direct leverage over payment levels to those physicians. On the other hand, some physician specialty groups could reverse the competitive pressures, accepting the full payment themselves and taking advantage of the oversupply of hospital beds to obtain hospital discounts—or even join together to purchase hospitals in which they will hospitalize their patients.

The combined payment also recognizes the close economic relationships that exist between hospitals and physicians, but which now drive up costs. Competition among hospitals is now primarily competition for physicians (who decide where to admit their patients), usually by adding more services and equipment which results in price-escalating competition. An integrated payment option would create incentives for hospitals to hold down unnecessary costs as a way to allow competing for physicians (and their patients) on the basis of more generous physician reimbursements.

Finally, a combined payment helps to prevent providers moving services from part A to part B billing as a way of getting around the hospital DRG payment system. With separate intermediaries and carriers for the two programs, HCFA now has no way to link hospital, physician, and other bills related to the same episode of care. The results of such linkage thus might be better quality reviews as well as better cost control.

There may be some disadvantages to a single, combined payment for inpatient services. With separate hospital and physician payments, a physician gets paid more the more tests, procedures, visits, etc., he provides for his or her patient; with a combined payment, the physician would not have as great an incentive to do more for the patient. As noted in the background material, 26 percent of practicing physicians now have financial arrangements with hospitals averaging 62 percent of their practice income, so such issues are researchable. As with most other issues regarding the SMI program, a continuing difficulty for assessment of reform proposals is lack of a data system which provides information on services now being paid for, price, and quantity data.

B. Assignment Policy

The medicare statute permits most physicians to decide, on a bill-by-bill basis, whether or not they will accept "assignment" of payment. This raises concerns about the possible adverse effects on the elderly from reforms of physician reimbursement methods, since restraint on Government payments could be passed on to the beneficiary. Such concerns for potential economic effects on the aged have been a major consideration in past debates over physician payment reforms.

The following sections review the medicare program's experience with assignment rates and then discuss several of the suggested ways in which current assignment policies could be modified to provide greater financial protection to the medicare enrollee.

1. ASSIGNMENT STATISTICS

The overall assignment rate for medicare physician bills declined from about 60 percent of claims in the late 1960's to a 50-percent rate in the mid-1970's and has increased slightly for the last several years. The trends of assignment rates based on total charges has followed a similar pattern.

TABLE 30.—MEDICARE ASSIGNMENT RATES

[In percent]

	Net assignment rate (claims)	Net assignment rate (charges)
Year:		
1970	61	(1)
1972	55	50
1974	52	48
1976	50	48
1978	51	50
1980	52	52
1982	53	54

[1] Not available.

Source: "Background Data on Physician Reimbursement Under Medicare," S. Prt. 98-106, October 1983, pp. 20, 21.

2. MANDATORY VERSUS VOLUNTARY ASSIGNMENT

Several studies indicate that the aggregate statistics on assignment rates tend to overstate the extent of protection enjoyed by most medicare beneficiaries. When joint medicare/medicaid claims—for which assignment is mandatory—are removed, voluntary assignment rates average about 11 percent lower than indicated by the aggregate statistics.

TABLE 31.—TOTAL AND VOLUNTARY ASSIGNMENT RATES, 1980

[In percent]

Specialty	Percent total reimbursement	Total assignment rate	Voluntary assignment rate
All physicians	100	50	39
Internal medicine	21	48	38
General/family practice	12	46	30
General surgery	11	51	41
Opthalmology	8	38	30
Radiology	5	60	50

Source: S. Prt. 98-106, October 1983, p. 109, citing DHHS/HCFA 1980 bill summary.

3. PHYSICIAN PRACTICE

Surveys have indicated that an estimated 18 to 19 percent of physicians always accept assignment, 28 to 30 percent never accept assignment, and the remaining 52 to 53 percent sometimes accept assignment and sometimes do not.[12] A variety of factors seem sta-

[12] Burney, I. L., Schieber, G. J., Blaxall, M. O., Gabel, J. R. "Medicare and Medicaid Physicians Payment Incentives." Health Care Financing Review, Summer 1979; 1(1): 62-78.

tistically related to variations in assignment rates. Physicians seem more likely to accept assignment for older patients than the younger elderly (59 percent assigned claims for the 85-plus age group in 1977 compared to 43 percent for the 65 to 69 group); to differ by specialty (a 39-percent assignment rate for internal medicine versus 46 percent for general surgery); to accept assignment more frequently on bills of $100 to $200 than on less expensive or more expensive bills.[13]

One factor which does not appear to have a strong connection to assignment rates is the extent of claims disallowance by medicare carriers. The Boston region, with highest proportion of claims reduced, for example, also had the highest assignment rate; the Denver region with lowest reductions was next to the bottom in percentage of assigned bills.

TABLE 32.—REASONABLE CHARGE REDUCTIONS AND ASSIGNMENT RATES, 1981

[In percent]

Region	Claims reduced	Assignment rate
Boston	87	67
New York	86	54
San Francisco	86	53
Seattle	86	30
Dallas	85	52
Chicago	83	49
Kansas City	81	40
Atlanta	79	53
Philadelphia	79	62
Denver	62	38

Source: DHHS/HCFA, "Analysis of Medicare Part B Assignment Rates," Calendar Year 1981. S. Prt. 98-106, pp. 33-34.

4. GEOGRAPHIC VARIATION

The preceding table illustrates perhaps the most important feature of medicare's assignment rates—they differ widely from area to area, with most of the variation apparently due to historical precedent, physician preferences, and/or carrier arrangements for their private business rather than to systematic differences in patient or physician characteristics. On a State-by-State basis, the range in assignment rates is far greater than among regional averages. In 1981, the medicare assignment rate was 82 percent in Rhode Island and 19 percent in Wyoming.

The wide variations in assignment rates across different regions mean that medicare beneficiaries in some States have far greater (or less) real financial protection from physicians bills than in other areas—although all pay the same monthly SMI premium. In States with lowest assignment rates 18 to 26 percent of users had to cope with more than $100 of liability for unassigned bills; in high assignment States only 3 to 10 percent of users had more than $100 of liability for unassigned claims.

[13] S. Prt. 98-106: "Background Data on Physician Reimbursement Under Medicare." October 1983, pp. 25, 26, 108.

TABLE 33.—PERCENT OF AGED WITH UNASSIGNED CLAIMS, 1978

[In percent]

	Percent of users with unassigned claims	Percent of users with $100+ liability for unassigned claims
States with low assignment rates:		
Oregon	92	18
Wyoming	91	26
Idaho	90	18
Arizona	90	22
Montana	90	20
Florida	90	19
States with high assignment rates:		
Rhode Island	51	3
Massachusetts	54	5
South Carolina	56	4
Mississippi	58	10
Maine	61	6
District of Columbia	62	10

Source: DHHS/HCFA, McMillan, A., Pine, P., Newton, M., "Medicare: Use of Physicians Services Under the Supplementary Medical Insurance Program 1975–1978," March 1983. S. Prt. 98–106, October 1983, pp. 59–61.

5. ASSIGNMENT OPTIONS

As long as a significant portion of claims remains unassigned, the possibility that physicians will respond to medicare fee restraint by simply shifting greater costs to their aged patients remains a serious problem. Three basic approaches to addressing this issue are: (1) To accept the problem as a way of creating a more "competitive" health care market; (2) to provide greater incentives for physicians to accept assignment; and (3) to expand mandatory assignment policies to include more physicians services. The three options are not entirely exclusive and could be combined in various ways.

(a) Continue Current Assignment Policies

The Reagan administration has proposed a temporary freeze on medicare's payment rates, but would allow physicians to continue their current assignment options for each claim and pass unreimbursed costs on to beneficiaries. Provider groups have also proposed such a course, making medicare more of an "indemnity" insurance program which leaves the aged at risk for amounts determined by the program to be unreasonably high.

The major rationale for such a policy is that, pursued over time, it will encourage the aged to "shop around" for health services so physicians will hold down prices in order to attract these patients. Concerns about such an approach can be raised in terms of medical care, health economics, and social policy. For most patients—and particularly the elderly—optimal medical practice suggests they should have a regular source of care, a physician who is well-acquainted with them as individuals, and whom they can rely on.

An indication that the public recognizes the value of such arrangements is that 89 percent of the population and 93 percent of the aged have established a regular source of medical care. Ameri-

cans seem relatively uninterested in using price as a major factor in medical care decisions; in a recent national study only 16 percent of Americans indicated they had ever used price as a factor in choosing a physician.[14] The elderly's reluctance to abandon these relationships for price considerations is reflected in the very low enrollment in HMO's, which is about half the rate of the under-65 population and comprised mostly of persons who joined the HMO's prior to reaching age 65.

Based on past experience, a more likely response by the aged to lower medicare insurance protection would be to buy additional "medigap" insurance. If medicare restraints are simply offset by such insurance coverage, little national cost restraint should be expected. Indeed, medigap insurance is considerably more costly for the aged than buying the same coverage through the medicare program. Even individual coverage medigap policies which meet the Federal standards of a 65 percent payout for each benefit dollar result in the aged spending about $1.50 for each dollar of benefits they collect. In contrast, medicare-medigap insurance, with a 4 percent administrative cost, could be sold for $1.04 premium for each dollar of benefits. Such considerations have led the Advisory Council on Social Security, for example, to recommend that the Government offer such medigap policies to the elderly for better SMI protection rather than seek to reduce SMI insurance to promote competition.

(b) Voluntary Assignment

Providing incentives for physicians to accept assignment would reverse some of the economic considerations which currently work against the aged. A physician who now accepts assignment for his or her services—benefiting senior citizens by limiting their out-of-pocket costs—loses the amount of money which his colleagues who do not take assignment are collecting. In 1982, this amount of "disallowed" charges averaged $28 per bill.

Several actions could be taken to encourage physicians to accept assignment. These incentives could be used to develop medicare "participating physician" arrangements for physicians who agree in advance to take assignment on all medicare claims. Such "participating physician" agreements are already widely and successfully used by Blue Shield plans. Where Blue Shield plans offer such arrangements, 80 to 85 percent of physicians have signed up. Under the terms of these agreements, physicians agree to accept the Blue Shield payment as payment in full for most patients, charging patients only for specified deductible and copayment amounts. Nationally, 58 percent of physicians have entered into such "participating provider" agreements with Blue Shield plans.[15]

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[14] Louis Harris & Associates. "The Equitable Health Care Survey: Options for Controlling Costs." August 1983. Survey highlights.

[15] Data provided by Blue Cross/Blue Shield Association. The terms of some agreements allow physicians to charge more than the Blue Shield payment for patients with incomes above a specified level.

(1) Information for primary care physicians and beneficiaries

Physicians who agreed to accept assignment on all medicare bills could be listed as "participating physicians" in brochures provided to both enrollees and referring physicians, along with other information such as specialization, affiliations, address and telephone numbers, and office hours. Such listing might be a particular inducement to physicians as it could lead aged persons concerned about costs to select them and also provide a guide for primary physicians who can benefit their patients by choosing to refer to qualified physicians on the list. Toll-free hot-line numbers and notices with social security checks could also be used to provide information about participating physicians.

(2) Automated claims billing and processing

More than 85 percent of medicare bills are still submitted and processed as paper claims, an administrative process which is costly, time consuming, and inefficient compared to state-of-the-art computer and communications technology. Medicare's administrative costs of $1 billion for the SMI program in 1985 include $1,500 to $2,000 for each of the Nation's physicians for paying his or her bills, and physician costs for recordkeeping and billing are probably equal or greater than the Government's. Placing terminals in physicians offices would offer advantages of cost savings and faster processing for medicare and physicians, and eliminate a heavy and often confusing problem for the aged in submitting and keeping track of the bills. A number of such systems have been demonstrated by various medicare carriers, such as Florida Blue Shield, now one of the lowest cost medicare carriers. Since such terminals could be used by carriers for their private business as well, some joint sharing of costs should be possible.

Other administrative improvements which could be incorporated into the "preferred provider" concept include: Simplified billings and administrative procedures, particularly for handling coordination of medicare and private medigap claims; and electronic funds transfer and periodic payments for high volume providers (e.g., hospital outpatient departments) as is now available for inpatient hospital services).

(3) Higher fees for assigned claims

Since medicare would save costs from better administration—and since the aged would benefit from having improved insurance protection against unreimbursed costs—these improvements could be recognized in somewhat greater medicare payments for participating providers. In the event of Congress adopting an interim fee freeze or limit proposal, tighter limits could be applied to unassigned than to assigned claims, so that physicians would have an incentive for accepting assignment rather than pass on higher costs to their patients.

The physicians who chose not to be "participating providers" could still be allowed to continue bill-by-bill assignment options.

(c) Mandatory Assignment

The third approach to dealing with assignment would be to expand the current mandatory assignment for hospital services and hospital-based physicians to a greater portion—or to all—physicians services paid by medicare. With this approach, either a physician would have to accept assignment for all services or his or her services would not be eligible for medicare reimbursement. With a growing supply of physicians (and oversupply in many metropolitan areas and specialties), medicare has probably become too large a factor in physicians incomes—about 18 percent or $18,000 per year—for most physicians to refuse to participate in the program, particularly when patients have many other physicians available who are able and willing to serve them.

TABLE 34.—*Medicare income by specialty, 1981*

	Percent of income
Surgical specialists	20
General surgeons	25
Ophthalmologists	24
Orthopedic surgeons	17
Thoracic surgeons	35
Nonsurgical specialists	17
Family practitioners	15
General practitioners	18
Internists	29

Source: Owens, Arthur, "How Much of Your Money Comes From Third Parties?" in Medical Economics, Apr. 4, 1983, p. 262. S. Prt. 98-106, October 1983, pp. 81, 82.

An alternative to requiring assignment on all physicians bills would be to extend mandatory assignment to all inpatient services, or to some portion of such services, e.g., inpatient surgery. This approach may be more acceptable to physicians than assignment for all services; excluding medicaid patients (for which assignment is mandatory), physicians accepted assignment for 41 percent of charges for their inpatient hospital services compared to 23 percent for office visits. As well, mandatory assignment for inpatient physicians services would be consistent with the current treatment of all other inpatient hospital services, which must be assigned. Such a change would also protect the aged against the highest potential charges disallowances—in 1980, inpatient charges accounted for 60 percent of total physician reimbursement, and inpatient surgery 27 percent. As shown in the following table, surgical bills—and disallowances—represent a much higher financial risk for the elderly than office-based visits.

TABLE 35.—COMPARISON OF SUBMITTED AND REASONABLE CHARGES, 1980

Service/specialty	Average charge submitted	Average reasonable charge	Difference
Surgery:			
General surgery	$320	$244	−$76
Specialized surgery	459	344	−115
Medical care:			
General practice	18	14	−4
Internal medicine	26	20	−6

Source: S. Prt. 98-106, October 1983, p. 104. DHHS/HCFA Extract from 1980 bill summary.

IV. CONCLUSION

Medicare's physician payment policies are no longer working well for the elderly, for taxpayers, or for many physicians. The SMI program's rising costs for paying physicians—which will make it the third largest Federal domestic program in 1985—are out of control and accelerating. Insurance protection for the elderly is being eroded by rising payment disallowances and by assignment policies which permit physicians to bill patients more than the medicare program's reasonable charge allowances. As well, the current CPR/UCR, fee-for-service payment policies provide incentives for unnecessary hospitalization, surgical and other procedures, and are inequitable for many physicians in primary care specialties.

As the Nation's largest payer of health services, medicare has many options for improving its payment policies. The program's physician payment policies could be shifted from provider-determined to Government-established rates through many competitive, fee schedule, and combined hospital/physician payment methods. Such reforms are critical to achieving cost restraint and to establishing incentives for appropriate health care. The Nation's elderly can benefit not only from such cost restraint, but also from improved insurance protection through higher assignment rates. Such improvements could build on the voluntary "participating physician" arrangements already accepted by most physicians for Blue Shield patients, as well as by expanding mandatory assignment.

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